Cialis, Levitra, Staxyn, and Viagra Prior Authorization Request Form

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To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: **TpharmPA@express-scripts.com**

Prior authorization criteria and a copy of this form are available at **http://pec.ha.osd.mil/forms_criteria.php**. This prior authorization has no expiration date.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Please indicate which medication is being prescribed: ☐ **Cialis** ☐ **Levitra** ☐ **Staxyn** ☐ **Viagra**

Step 2 **Please consider the following:**

- Patients taking nitrates, either regularly or intermittently, should not receive PDE-5 inhibitors. Patients should be informed of the consequences should they initiate nitrate therapy while taking a PDE-5 inhibitor.
- Please see product labeling precautions for concurrent use with alpha blockers.

Step 3 **1. Please indicate the patient's gender.**

Female	Please go to **Section 1** for **Female patients**
Male	Please go to **Section 2** for **Male patients** on Page 2

Section 1 – Female patients

1. Is the PDE-5 inhibitor being prescribed for the treatment of sexual dysfunction?	☐ Yes **Coverage not approved**	☐ No **Proceed to** Question **2**
2. Is the PDE-5 inhibitor being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	☐ Yes **Coverage approved** Please complete Question 4	☐ No **Proceed to Question 3**
3. Is the PDE-5 inhibitor being prescribed for a diagnosis of Raynaud's phenomenon?	☐ Yes **Coverage approved** Please complete Question 4	☐ No **Coverage not approved**
4. What is the dosing regimen?		

Please go to Step 4 on Page 3.

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Section 2 – Male patients

1. Is the requested medication Levitra?	☐ Yes **Proceed to Question 2**	☐ No **STOP.** Go to **Section 3 on Page 3**
2. Is the patient 18 years of age or older?	☐ Yes **Proceed to Question 3**	☐ No **Proceed to Question 6**
3. Is the patient 40 years of age or older?	☐ Yes **Do not submit form.** Prior authorization is not required for males 40 years or older.	☐ No **Proceed to Question 4**
4. Is the PDE-5 inhibitor being prescribed for the treatment of erectile dysfunction of organic origin? Organic impotence is considered a consequence of chronic medical conditions that result in impaired arterial blood flow or nerve damage, mixed organic/psychogenic causes, and necessary use of causative medications that cannot be reduced or discontinued. TRICARE regulations specifically exclude coverage of therapies for erectile dysfunction that is not of organic origin.	☐ Yes **Coverage approved**	☐ No **Proceed to Question 5**
5. Is the indication for the preservation or restoration of erectile function following prostatectomy?	☐ Yes **Coverage approved** To determine quantity requirements, please complete Question 8	☐ **No** **Proceed to Question 6**
6. Is the PDE-5 inhibitor being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	☐ Yes **Coverage approved** To determine quantity requirements, please complete Question 8	☐ **No** **Proceed to Question 7**
7. Is the PDE-5 inhibitor being prescribed for a diagnosis of Raynaud's phenomenon?	☐ Yes **Coverage approved** To determine quantity requirements, please complete Question 8	☐ **No** **Coverage not approved**
8. What is the dosing regimen?		

Note: For treatment of erectile dysfunction of organic origin unrelated to therapy for preservation or restoration of erectile function following prostatectomy, coverage is limited to a collective quantity (sildenafil, vardenafil and/or tadalafil combined) of 6 tablets per 30 days or 18 tablets per 90 days.

Please go to Step 4 on Page 3.

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Section 3 – Male patients – Cialis, Staxyn, and Viagra

1. Has the patient received a trial of Levitra (vardenafil) and had an inadequate response?	☐ **Yes** **Please sign and date**	☐ **No** Proceed to Question **2**
2. Has the patient received a trial of Levitra (vardenafil), but was unable to tolerate it due to adverse effects?	☐ **Yes** **Please sign and date**	☐ **No** Proceed to Question **3**
3. Is treatment with Levitra (vardenafil) contraindicated for this patient (e.g., due to hypersensitivity)?	☐ **Yes** **Please sign and date**	☐ **No** Proceed to Question **4**
4. Is the requested medication being used for treatment of pulmonary arterial hypertension (PAH)?	☐ **Yes** **Please sign and date**	☐ **No** Proceed to Question **5**
5. Is the requested medication being used for treatment of Raynaud's phenomenon?	☐ **Yes** **Please sign and date**	☐ **No** Proceed to Question **6**
6. Is the requested medication being used for preservation/restoration of erectile function after prostatectomy?	☐ **Yes** [1] **Please sign and date** **Please complete Question 7**	☐ **No** Proceed to Question **8**
7. What is the dosing regimen?		
8. Is the requested medication **Cialis 2.5 mg or 5 mg taken once daily**?	☐ **Yes** Proceed to Question **9**	☐ **No** **STOP** **Coverage not approved**
9. Is Cialis being prescribed for the treatment of signs and symptoms of benign prostatic hypertrophy (BPH)?	☐ **Yes** Proceed to Question **10**	☐ **No** **STOP** **Coverage not approved**
10. Has the patient tried tamsulosin or alfuzosin and had an inadequate response?	☐ **Yes** [1] **Please sign and date**	☐ **No** Proceed to Question **11**
11. Has the patient tried tamsulosin or alfuzosin and was unable to tolerate it due to adverse effects?	☐ **Yes** [1] **Please sign and date**	☐ **No** Proceed to Question **12**
12. Is treatment with tamsulosin or alfuzosin contraindicated (for example, due to hypersensitivity)?	☐ **Yes** [1] **Please sign and date**	☐ **No** **Coverage not approved**

[1] Authorizations for preservation/restoration after prostatectomy and for BPH are effective for 1 year.

Please go to Step 4.

Step 4

I certify the above is correct and accurate to the best of my knowledge. Please sign and date:

Prescriber signature _____ Date _____